First Nations and Inuit
Home and Community Care Program

Annual Report
1999
2000

Health Canada / Santé Canada

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INUIT TAPIRIIKSAT KANATA
Inuit Tapiriit of Canada

Report prepared by:

National First Nations and Inuit Home and Community Care Team which is comprised of Assembly of First Nations (AFN), Inuit Tapirisat of Canada (ITC) and First Nations Inuit Health Branch (FNIHB), Health Canada representation.

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Message from the National Steering Committee on First Nations and Inuit Home and Community Care Program

Immediately following the announcement of the National First Nations and Inuit Home and Community Care Program in the February 1999 Budget, we began to plan how we could best implement this new program in a manner that respected the principle of collaboration. The collaborative process would enable us to create an environment for effective planning and implementation of the Home and Community Care Program and ensure accountability to all stakeholders.

Our achievements in meeting this challenge and other stated objectives in Year 1 of planning and implementation are reported in the Program's 1999-2000 Annual Report. We are pleased to share this Report with you as it represents an important contribution to Program accountability.

As you will read, significant developments in laying a foundation for program planning took place. The objectives for Year II support further collaboration and a focus on community based planning for the new program.

The challenge throughout these developmental years will be to balance effective program development which takes time to achieve with the need to deliver quality services to potential program recipients.

It is out hope that this Report demonstrates that at all levels – national, regional and community – we are all working towards the same goal.

Paul Glover
Co-Chair

Chief Margerey McRae
Co-Chair

The philosophy of supporting client independence and only doing what the client cannot do for themselves is an essential part of home care.

Program Vision

The First Nations and Inuit Home and Community Care program will provide basic home and community care services that are comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians and which respond to the unique health and social needs of First Nations and Inuit. The program is a coordinated system of home and community based health related services which enable people with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their home communities.

Program Objectives

To build the capacity within First Nations and Inuit to develop and deliver comprehensive, culturally sensitive, accessible and effective home care services.

To assist First Nations and Inuit living with chronic and acute illness in maintaining optimum health, well-being and independence in their homes and communities.

To facilitate the effective use of home care resources through a structured, culturally defined and sensitive assessment process to determine service needs of clients and the development of a care plan.

To ensure that all clients with an assessed need for home care services have access to a comprehensive continuum of services within the community, where possible.

To assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients.

To build the capacity within First Nations and Inuit to deliver home care services through training and evolving technology and information systems to monitor care and services and to develop measurable objectives and indicators.

INTRODUCTION

The following report represents the activities and developments that have taken place with respect to the implementation of the First Nations and Inuit Home and Community Care Program for the 1999-2000 fiscal year. This report is intended to inform First Nations and Inuit, federal government departments and other stakeholders on the status of this new program initiative. During the initial year of this new program, the National Steering Committee set out to:

- establish a governance and management infrastructure to oversee the program during its initial three year developmental period;
- obtain the necessary authorities to release the funding; and
- develop a planning and implementation framework that supported principles of collaborative working relationships, transparent and evidence based decision making, timely and consistent communication, capacity building and planned based approach to program delivery.

This reports provides a detailed report about the achievements as well as the problems encountered in implementing this new program initiative.

BACKGROUND

During the 1998-99 fiscal year, Medical Services Branch (MSB) and the Department of Indian Affairs and Northern Development (DIAND) invited First Nations and Inuit to collaborate on the development of a comprehensive Continuing Care Strategy. Prior to this, the two government departments had a series of meetings to discuss the emerging issues of the continuing care requirements of First Nations and Inuit. Health reform activities were being undertaken by provincial governments thereby placing First Nations and Inuit in a position of having to respond to the impacts of these reforms without the additional resources required to adequately respond. In addition policy and mandate issues related to the provision of continuing care were identified in both the (DIAND) and (MSB). These issues in themselves prevented the realization of the goal which was to achieve a continuum of services that were delivered in a coordinated and integrated manner. Within the initial six month period of this new collaborative partnership, the first phase of the continuing care strategy was completed - the development of a framework for First Nations and Inuit Home Care. The outcome of this collaborative effort set the stage for the collaborative nature of further developments in continuing care.

In February 1999, the federal government announced funding in the amount of $152M, over a three year period for the establishment of a First Nations and Inuit Home and Community Care Program, with $90M ongoing for program delivery and support. It was intended that this program would be implemented in a three-year developmental period and would be carried out in a collaborative partnership between MSB and First Nations and Inuit.

This collaborative process was initiated with the establishment of a National Steering Committee which was struck to oversee the development and implementation of this program over its initial three years. The committee is comprised of 10 members, 5 First Nations and Inuit representatives and 5 federal government representatives. The First Nations representatives were appointed from the Chiefs Committee on Health of the Assembly of First Nations and the Inuit representative was appointed from Inuit Tapirisat of Canada. The federal government representatives come from both MSB region and headquarters and DIAND.

OVERVIEW OF ACTIVITIES AND PROCESSES TO REALIZE FUNDING

Although the funding was announced in February 1999, there were a number of processes to be followed to achieve the actual flow of funding. These processes have traditionally been internal activities undertaken by MSB. Due to the nature of the partnerships developed, a collaborative approach was taken among First Nations, Inuit and MSB within the extent that maintained government secrecy regulations, but enabled First Nations and Inuit involvement in the design of the program description, program outcomes, accountability framework, planning requirements and funding principles.

Cabinet Authorities

The first process required was to obtain policy approval for the First Nations and Inuit Home and Community Care program. MSB took the lead role in obtaining the required policy approval. This was necessary as the branch did not currently have Home and Community Care Program within its mandate. First Nations and Inuit were advised that the First Nations and Inuit Continuing Care Framework, Phase One- Home Care was used as background and content of the policy approval. The authorities received for this new program were:

- overall funding levels;
- program design which built links with current home nursing and DIAND's Adult Care Program (In-Home Component);
- program model of "Reach for the Top" including essential program elements and supportive services; and
- mandatory program after three years and eligible for transfer.

Treasury Board Approval and Authorities

After Cabinet policy approval was received the next process to implement was the preparation of a Treasury Board Submission. The Treasury Board Submission (TBS) outlines the program authorities and the basis on which funding is approved. The TBS must contain:

- funding levels by program activity;
- terms and conditions of funding;
- detailed program framework, design and implementation plans;
- accountability framework; and
- other background information detailing how the program will meet Cabinet approvals.

The required content for the submission and the time frame options for the submission were presented to the National Steering Committee. The direction provided was: to realize a fall submission to Treasury Board in order to draw down money in Year One; and to obtain input into the TBS process through the implementation of a series of Information Sharing and Feedback discussions to be held throughout the country. This was not a consultation process but rather a process that provided information and solicited feedback into the Treasury Board Submission as well as program planning and development requirements.

While the overall direction on the Information Sharing and Feedback was national in nature, the planning and implementation of it was very regional and territorial in its execution. To ensure that this process met the needs of First Nations, Inuit and regional government staff, a national orientation and planning session was held with representatives from MSB, First Nations regional health technicians, DIAND and Inuit representatives. The agenda, core questions, dates and validation processes to guide these discussions were developed at this national gathering. The fall submission required very tight time frames for the roll out of this plan and it was decided that the regional meetings would be held during the months of July and August. Despite this schedule, over eight hundred (800) people attended regional meetings. The location and dates for these meetings were co-ordinated regionally. MSB and AFN National Home and Community Care program coordinators or ITC

representatives attended all of the meetings and provided information on the new program but did not actively participate in the discussions.

Each Region/Territory provided a report on the information session(s) held in their respective regions/territories and draft documents for the Treasury Board Submissions were prepared. Prior to these documents being reviewed by the National Steering Committee, a validation meeting was held with regional representatives to ensure that the contents of the documents accurately reflected the input obtained during the regional and territorial meetings. The National Steering Committee then reviewed, modified and approved the Treasury Board annexes to be forwarded. Treasury Board approval was obtained on November 18, 1999. Approved Authorities included:

- adjustments to MSB Branch funding levels in accordance with approved program funding;
- amendments to the terms and conditions of integrated agreements;
- inclusion of Home and Community Care as one of the health programs eligible for transfer effective 2002/03;
- program framework and criteria; and
- accountability framework.

Further explanation of these authorities can be found as an appendix to this report.

Allocation and Distribution of Available Funding

The following table represents the allocation and distribution of funding for this program over the next three years and ongoing from Year four.

First Nations and Inuit Home and Community Care
Detailed Financial Breakdown (In Millions) Revised April 28, 2000

FUNDING ITEM	1999-2000	2000-2001	2001-2002	2002-2003 (and future years)
OPERATING				
National	1,879.6	1,350	1,235	978
Regional Coordination and 3rd Level Program Support	640	1,600	1,600	2,000
Evaluation and Research	0	0	250	350
Corporate Services Branch	45.4	33.5	34	34
Communications	170	45	900	900
CONTRIBUTIONS				
Program Planning and Service Delivery	12,650	22,416	66,209	85,738
Training	1,615	5,650.5	5,272	0
Capital	0	13,500	14,500	0
TOTAL	**17,000**	**45,000**	**90,000**	**90,000**

Regional Coordination and 3rd Level Program Support Amounts

Year	1999-2000	2000-2001	2001-2002	2002-2003
Amount Per Region	80,000	200,000	200,000	250,000

The available resources will be allocated through the application of the program specific funding formula. The funding formula was developed with a foundation of the following 9 principles: flexible; sustain ability and longevity; integration and linkages; accountability; accessible; needs-based; plan based; non-penalization; and non-duplication.
The formula was approved based on the understanding that a strategy must be developed and implemented to move towards a truer definition of needs-based in the financial table. The terms 'operating' and 'contributions', are government defined categories of funding.
There have been concerns and objections raised about the amounts identified for Communications and Corporate Services Branch. In an effort to be transparent and accountable for the full resources available, these amounts are been reflected in the overall allocation table. These amounts are determined external to MSB and are required allocations.
The amounts available for national level activities are accounted for in a national work plan to support the ongoing development and implementation of the program and incorporate the collaborative activities for First Nations, Inuit and government partners. Further on in this report, priorities for 2000/2001 are referenced.

The breakdown of the allocations were approved by the National Steering Committee and each region has received information about the funding available for Year 2, Year 3 and ongoing. This long term information was identified as essential to enable communities to plan with the required information.

SUMMARY OF DEVELOPMENTAL AND PLANNING ACTIVITIES

National Steering Committee

The National Steering Committee has met on a quarterly basis and has provided direction and approval on the following:

- Approving the national direction and implementation plans for the Home and Community Care Program;
- Identifying and approving the funding formula that will be used to allocate funds for program development and on-going delivery;
- Providing the direction for the development of a Strategy to realize a needs based approach to funding;
- Approving the Principles and criteria for utilization of both capital and training resources;
- Approving the content of the annexes for the Treasury Board Submission;
- Identifying and recommending for consideration, linkages with other First Nations, Inuit, MSB, Provincial/Territorial/Municipal governments and DIAND programs (e.g. Adult Care, Home Nursing, Housing);
- Providing direction for the establishment and work plans of task specific working groups;
- Providing input to the Joint Working Group on Continuing Care on the Institutional Care Framework; and
- Communication activities to facilitate good communication on program developments.

It is expected that the National Steering Committee will remain in effect during the three- year developmental period of this initiative. However, this mandate may be revised depending on the status and outstanding issues that remain after the three year period.

Establishment of Task Specific Working Groups

During the beginning of the first year of the program, it became apparent that there was a tremendous amount of work that was required to be carried out to ensure that the regional developmental activities could be supported. By providing national support to a number of critical issues, First Nations and Inuit could concentrate their efforts in carrying out their needs assessments and detailed planning activities. The National Steering Committee approved the establishment of four 'task specific' working groups who would be responsible for the development of framework documents that First Nations and Inuit could adapt, modify or use. The membership of these working groups was not determined by regional or geographic representation but rather on the skill sets of individuals whether they were First Nations, Inuit or MSB or DIAND staff. The working groups cease to function as soon as their tasks are completed. It is expected that all of the tasks will be completed by the end of the 2000-2001 fiscal year. The working groups are described as follows:

Working Group on Planning Resource Development

This working group was established in response to a number of recommendations made by First Nations and Inuit during the Information Sharing and Feedback Sessions. The purpose of this working group was to develop resources that could be used by First Nations and Inuit in their planning activities. As a result, a Planning Resource Kit was developed and distributed in the latter part of the 1999-2000 fiscal year. This kit contained information on conducting needs assessments, program planning, training, capital as well as a number of supporting documents, including: a general pamphlet on the program to assist with building awareness; and a planning flow chart that reinforced the principle of community based, community paced approach. There has been a lot of positive feedback on the resource kit not only in its appearance but also with the contents. Additional handbooks are under development and will be distributed as they become available. The handbooks have also been placed on the program's web page and can be downloaded.

Working Group on Standards, Scope of Practice, Training & Liability

One of the principles for the First Nations and Inuit Home and Community Care Program calls for the establishment of programs that are equitable to that enjoyed by other Canadians. One of the ways of achieving this is to facilitate the understanding of how standards, scope of practice, training and liability related issues impact the quality and type of service provided. The working group has provided direction on how these issues can be addressed and the work required in Standards and Liability have been contracted externally. St. Elizabeth's Health Care in Markham Ontario are developing generic standards that can be adopted, adapted or modified by First Nations and Inuit. This work should be completed and distributed by September 2000. The Aboriginal Nurses Association of Canada is developing a discussion paper on potential issues of liability as it relates to the delivery of home and community care.

The issues around scope of practice and competencies will also be addressed and completed as a sub group of this overall working group and will involve First Nations, Inuit and government representation. This work should be completed within the 2000-2001 fiscal year.

The training criteria, funding framework and reporting requirements has now been completed. The evaluation plan on the utilization and outcomes of the training resources has not been developed. Although the funds are being maintained at the national level until a regional plan is submitted, regions have been advised of their notional allocations for planning purposes.

Working Group on Evaluation, Accountability and Information Management

This working group was involved in the preparation of the Accountability Framework that was included in the Treasury Board Submission. The Accountability Framework is the first document prepared for Treasury Board that clearly outlines the accountability responsibilities of the Minister of Health, Medical Services Branch and First Nations/Inuit. Both First Nations and other government departments have since used this framework document as they work towards developing detailed accountability frameworks.

The Evaluation Framework will be completed during this current fiscal year and will be supported by a Handbook to assist communities to facilitate the development of an evaluation plan that meets their program planning and delivery needs. The First Nations and Inuit Home and Community Care Program will be developing linkages with the First Nations Health Information Systems to have the issues of Information Management addressed. A draft of a tracking tool document to monitor program developments has been forward to First Nations, Inuit and MSB for their feedback. It is expected that some of the items contained in this document will be incorporated into the Information Management system.

Working Group on Non-Insured Program Linkages

One of the essential elements of the Home and Community Care Program is access to and provision of medical supplies and equipment. A working group was established to identify strategies and foster linkages between the Home and Community Care Program and the Non-Insured Health Benefits and other drug distribution programs to ensure quality access to client care in a manner that is timely, seamless and cost effective. Activities of the working group are underway and should be completed by October 2000. The information and recommendations developed by the working group will be shared with First Nations and Inuit communities for consideration in the development of program and capital plans.

Capital and Training Resources

The National Steering Committee approved that funding for both capital and training would be allocated through the application of the approved Home and Community Care funding formula. Funding would be released for both training and capital with the submission of regional plans for each fiscal year. The development of both plans in regions and territories need to be carried out in a collaborative process that includes a communication strategy on plan developments and contents.

An evaluation on the utilization of both capital and training resources and its impact on program delivery will require that the utilization of these funding resources will need to be carefully tracked in order to determine what capital and training needs were met to support the delivery of home and community care services and what gaps remain. Linkages with other potential funding opportunities through telehealth related and Human Resources Development Canada sources need to be considered in the development of regional plans for both capital and training.

Capital

As has previously been indicated capital resources have been identified in Year 2 and Year 3 of the development of this program. A total of $28 million nationally has been dedicated to capital related activities. Capital planning is one component of the planning activities described in the Planning Resource Tool Kit. The draft of the capital criteria was presented for consideration to the National Steering Committee in January, 2000. It has since been revised based on the direction provided at that meeting and will be incorporated into the Resource Kit as a separate handbook.

Regions and Territories are expected to work with their partners to develop a Regional Capital Plan. Eligible expenditures include:

- Expansions of current health facilities;
- Construction of health professional accommodation for Types One and Two communities only (Based on CWIS definitions); and
- Capital Equipment for both start-up and program delivery.

Training and Capacity Building Activities

A total of $12.5 million nationally has been dedicated to training related activities. As the table summarizing the funding indicate, there was funding made available for training during the 1999-2000 fiscal year. This was done in response to information received in the Information Sharing and Feedback sessions that some communities were at the training stage in their program development and to support the principle of "community based and community paced" some funding for training should be made available. Therefore $1.6M of the $12.5M (or 13%) was made available nationally for training activities in the first fiscal year. While the allocation level and criteria was not approved until January 2000, and collaborative processes were just getting underway in a number of regions, a 'one time' proposal/plan submission process to access training resources was developed for the initial year. A call for training proposals was sent out in early February for interested First Nations and Inuit communities to submit training proposals.

These submitted training plans were then reviewed against the approved criteria and recommended for funding if they met the criteria. The recommendations for funding the submitted training plans was forwarded to the National Steering Committee and approved. In addition, Regions were invited to access a notional allocation of $88,000 with the submission of a plan for resource utilization. A number of regions did submit plans and funding was released. It is expected each region will provide a summary of program activities and expenditures by early summer.

In addition the National Steering Committee recommended that training modules be developed to support planning activities in the regions. Two training modules were developed and piloted and were:

a) Peer Review Trainer of Trainers module to facilitate the development of the peer review process that is required for all submitted service plans; and

b) A training module to assist communities to use their needs assessment in developing a service plan for the delivery of their home and community care program that incorporates the essential elements. Both of these modules will be tools that will be distributed to each region to support capacity building activities.

Finally a national information sharing and capacity building workshop was held in Markham Ontario to provide information and one model of how second and third level services could be provided to support the delivery of quality community based home and community care services. Approximately 70 people from across the nation attended this session. An evaluation of the learning outcomes was conducted and follow up on information requests by participants will be provided on the program's web page.

Communication Activities

With the onset of the program a communication strategy was developed, approved and implemented. The primary goal of the strategy was to keep all of the partners informed about the developments with respect to this new program. Throughout the initial year of this program's development the communication strategy was revisited several times to try to improve how communication was occurring on the program. Issues of timeliness and clarity of information have been raised, and each time there has been attempts to respond and improve. Communication activities have included:

- Preparation and distribution of information letters to communities about program developments from the Co-chairs of the National Steering Committee;
- Development of First Nations and Inuit Home and Community Care web page;
- Development and distribution of planning resource tool kit, produced in 3 languages;
- Development and distribution of program pamphlet for household distribution, produced in 3 languages;
- Conducting Information Sharing and Feedback sessions held throughout the country;
- National meeting of regional/territorial government, First Nations and Inuit program contacts to launch planning resources;
- Distribution of program annexes to the TB submission, development of presentations to explain government processes and authorities received;
- Number of Regions/Territories participated in the writing of information articles for local First Nations and Inuit publications;
- One region is producing a video to share information and increase awareness of the new program;
- Regional information workshops;
- Presentations at conferences; and
- Regular conference calls with regional MSB/First Nations/Inuit coordinators.

Each region has been asked, as part of their work plan, to develop a communication plan to ensure timely, accurate information on this new program. There are a number of reasons and potential uses for this annual report, the significant one, though, is to communicate to all stakeholders about:

- what has and is occurring with respect to the program;
- why it has and is occurring; and
- what the future plans are for the program.

A statement supporting wellness and independence is usually a foundational piece of a Home Care Mission Statement.

SUMMARY OF NATIONAL, REGIONAL AND TERRITORIAL ACTIVITIES, PARTNERSHIP DEVELOPMENT AND STATUS OF PLANNING

The National Steering Committee established the overall objectives for Year One of the program. The objectives were:

- To establish the infrastructure and collaborative process required within regions and territories to facilitate program developments and implementation;
- To develop the planning process that would support the achievement of both the program vision and objectives;
- To establish a process to facilitate timely communication and information sharing on program development and implementation;
- To foster the development of networking and linkages with programs and organizations to enable access to the 'right care at the right time';
- To facilitate capacity building at all stages of program development and implementation; and
- To enable communities to commence needs assessment and planning/training activities for service delivery.

Each region and territory was requested to develop a work plan in a collaborative manner to realize program planning developments for the 99/00 fiscal year. The following provides an overview of how the National team and each region and territory worked towards achieving the program objectives for Year One.

National Team

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- Establishment of a National Steering Committee with appointed representatives from the CCOH, AFN, the Inuit Tapirisat of Canada, Department of Indian Affairs and Northern Development, and Medical Services Branch which is mandated as a decision making authority;
- FNIHCC team established with program implementation capacity at MSB, AFN and ITC;
- Strong program relationship and linkage with DIAND established;
- A collaborative approach was taken in the:
    - development of all program documents;
    - determination of work plan and priorities;
    - the planning and implementation of Information Sharing and Feedback Sessions held across the nation; and
    - report preparation, strategy development and required briefings to government, AFN and ITC authorities;
- Developed and distributed regional work plan templates for planning and report preparation to all regions and territories;
- Prepared Statement of Professional requirements for third level home care expertise;
- Established communication with program contacts in all Regions and Territories; and
- Responded to invitations to provide information at regional level meetings.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- Held information sharing and feedback sessions with over 800 participants across the nation to obtain input into both the Treasury Board submission and program design;
- Developed the program planning resource tool kit in response to a nation wide identified need which reflected the lessons learned from the First Nations Health Transition fund pilots on Home Care;
- Developed and approved a program specific funding formula that can be evaluated against actual needs;
- Identification and funding allocation to recognize and support the need for third level home care program expertise for program implementation; and
- Established task specific working groups to carry out work on policies and standards, evaluation framework, information system development, liability related issues; training and scope of practices.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- Developed and implemented communication strategy;
- Established process to prepare and distribute communications from the National Steering Committee post meeting to be distributed to communities and stakeholders;
- Establishment of program specific Web site;
- Institution of program teleconference call for First Nations, Inuit, MSB program staff; and
- Distribution of the same documents to all partners.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

- Held Information sharing meeting for aboriginal and non-aboriginal national organizations;
- Held Information meetings with provinces, territories, Inuit and First Nations regional authorities;
- Initiated discussions with other federal departments to build program linkages;
- Participation on F/P/T committee on the development of home care indicators;

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Information Sharing and Feedback sessions held across the country contained information about government processes to enable First Nations and Inuit to become more aware of government processes and to have input into the preparation of the Treasury Board Submission;
- Development of resource tool kit was designed to enable communities to carry out program planning activities;
- Production of two training modules (Peer Review and Service Plan development) to assist community planners and regional teams to carry out their work;
- Made funding for training and capacity building activities available to regions and territories;
- Organized an information sharing/capacity building session on second and third level program supports for program delivery; and
- Delivered training to support peer review activities and service plan preparation available to representatives from all Regions and Territories.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- Funding was allocated to all regions and territories to commence program planning with a significant number of communities receiving funding for program planning;

- First three handbooks of Planning Resource Kit was made available to communities, Tribal Councils and regions, as well as on the Web site for the program in 3 languages; and
- Peer Review process established as a National requirement for all service delivery plans submitted by communities.

Pacific Region

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- MSB employed a nurse to take the lead role for program implementation;
- Collaboratively developed Information Sharing and Feedback sessions in the summer of 1999 at 10 locations with 114 participants in attendance;
- Regional Steering Committee is being developed and membership recommended in March 2000 with representation from B.C. Chiefs Health Committee, DIAND, MSB and the Province. Committee will be responsible for developing criteria and implementing an approval process for needs assessment, program and implementation funding. The Peer Review Committee will be responsible for first reviewing the plans for program feasibility, viability and sustainability. As well, the Peer Review Committee will offer feedback and make recommendations for funding;
- Decision made to allocate funding to staff 4 program resource persons, two will be First Nations employed and two MSB employed; and
- Year One plan not available and Year Two plan is in progress.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- Orientation sessions planned throughout the region to increase awareness and understanding of the new program;
- Peer Review membership has been identified and training plans are in place; and
- Chief's Health Committee has contracted with an Aboriginal consulting firm to assist communities with needs assessment and the planning resource kit.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- The Regional Joint Steering Committee will develop a strategy for communication and education, as well as establish and maintain linkages with national sub working groups on Home and Community Care developments; and
- MSB contracted Nuu-chah-hulth Tribal Council to produce a video about Home and Community Care.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

The Regional Joint Steering Committee provides a regular and formalized forum for the exchange of information and integration of services. The committee meetings provide an opportunity to discuss DIAND's Adult Care allocations and how the services may complement the home and community care program, community initiatives and to eventually develop a single reporting requirement for the two programs.

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Five British Columbia First Nations groups were funded for training projects to increase the number of qualified Personal Care Attendants; and
- The Regional Joint Steering Committee is also tasked with ensuring access to technical expertise. Through the contracted consultants and the Peer Review committee, there is an ensured process of advice and assistance.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- 31 First Nations and/or First Nations organizations representing a total of 106 First Nations received funding to commence planning activities; and
- All communities received a copy of the planning resource kit and planning sessions are being organized.

Alberta Region

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- A regional home and community care implementation committee have been meeting monthly since September 1999 with representation from MSB, each Treaty area (Treaty 6,7,8) and DIAND;
- Year One Work plan developed and reported against, Year Two plan established and under implementation;
- The activities of the Peer Review process have been very extensive and 16 plans have been reviewed and recommended for implementation; and
- Some First Nations with larger populations and potentially some Tribal Councils will be establishing a loaner pool of medical supplies and equipment to support home care delivery.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- A sub working group established to implement processes supporting accountability, standards and quality assurance;
- A sub working group on capital established and will be consulting with Regional Capital committee, capital planning process in place; and
- Training and information sessions have been conducted in collaboration with regional personnel from Medical Services Branch. The training and information sessions have been all treaty area based. Sessions were held twice in the past year. Regional Implementation committee has also received information re: INAC's funding identified for training to First Nations. e.g., Education, Pre-vocational Training and Work Opportunities Program, National Child Benefit re-investment.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- A communication sub working group has been established to realize timely information sharing and communication protocols are in place. Letter signed by the Regional Director General, INAC and Regional Director, MSB have been sent to Chief and Councils, Social Services and Health Directors advising the First Nations of the developments in home and community care.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

- Linkages are being developed with DIAND, HRDC and NIHB. DIAND is participating with community visits to support planning, and are participants in the peer review process and sit on the Regional Implementation Committee. Integration and coordination of programs at the community level are being facilitated at all community visits; and
- Discussions have occurred with Alberta provincial health with respects to assessment processes and standards.

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Participation in both pilot training opportunities on Peer Review and Service Plan preparation.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- First Nations in Alberta completed community needs assessments in March 1999 and service plan completion is targeted for March 2001; and
- Information sessions and training was held in each Treaty area to assist communities to prepare service plans.

Saskatchewan Region

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- Three area coordinators with home care expertise have been employed to assist communities in planning for the new program, one for the North, one for central area and one for the southern area. As well both Medical Services Branch and the Federation of Saskatchewan Indian Nations will employ program coordinators;
- Year One Work plan prepared and report prepared; and Year Two Work plan not developed;
- Collaborative planning process under development with roles of various stakeholders being clarified;
- Process planned for peer review which will be comprised of nurses, elders and community members. Training pool of 21 peer reviewers will commence by early summer; and
- Capital Planning process under development.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- Funding allocated to First Nations communities and Tribal Councils to initiate planning activities.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- Numerous meetings have been held to provide the leadership, health directors, Tribal Councils and communities information about the new program.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

- DIAND is participating with the planning and implementation of the program.

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Participation in both pilot training opportunities; and
- Some Tribal Councils and communities have initiated training of Personal Care Workers for the new program.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- Approximately 90% of the communities have some level of Home Nursing and communities were offered the option to allocate 30% of funding for 99/00 to support existing home nursing services as an incentive to remain with the community in what has become a highly competitive market for nurses; One band and 1 tribal council comprised of 7 communities choose to place all funds in needs assessment activities.

Manitoba Region

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- A Regional and Implementation Committee for the program has been established with Terms of Reference developed;
- Focus teams have been developed to carry out task specific work for planning and developmental purposes;
- A program manager (on interchange) and a Regional Coordinator, both MSB employed and First Nations nurses, have been recruited to rollout the program; and
- Assisted the 7 Tribal Councils in hiring Home and Community Care Tribal Coordinators to assist communities with program planning, coordination and development.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- 100% First Nations communities are working on their needs assessments - Phase I. Training requirements are being identified in all communities. The program's Resource Tool Kit is being utilized for preparation activities for the next phase-Home Care Plan/Service Delivery Plan by a few communities.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- Bimonthly committee meetings are being held;
- Needs Assessment workshops held in both the Northern and Southern part of the Region;
- Numerous community visits conducted; and
- Correspondence and/or telecommunication with all Chiefs and Councils; First Nations membership; Nurses-in-Charge; private and other government authorities has been carried out.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

- Interdepartmental meetings held to include all regional partners linked with the First Nations and Inuit Home and Community Care program;
- Program linkages with home care organizations and provincial health authorities have been identified at the community level.

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Participated in both national training pilots on peer review and service delivery plan development.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- Communities have been allocated financial resources for Needs Assessments - Phase I;
- Communities have received Planning Resource Tool Kit; and
- Needs Assessments Workshops held in the northern and southern part of the region.

Ontario Region

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- Collaborative planning processes are under development;
- Year One Regional Work plan: Health Directors from each PTO provided direction to Medical Services Branch on how year one would unfold. That direction was in the work plan Contribution agreement between Medical Services Branch and the Chiefs of Ontario. The year one work plan was extended to August 31, 2000 to enable tasks to be completed at an acceptable community pace and allow communities to develop their base funding on how they wished to proceed. Due to the tight time frames other deliverables such as the training work plan, capital plan and partners work plan were allowed additional time;
- Chiefs of Ontario contracted a program coordinator for Year One;
- Medical Services Branch Ontario Region seconded a CHN - 06 for two years as the Regional Home and Community Care Coordinator; and
- Year Two regional work plan will commence when management structure is agreed to by the Health Directors, Chiefs of Ontario and Ontario Region.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- Each of the four PTO's and Independent First Nations in Ontario region decided to unfold the Home and Community Care program differently due to the unique environment of each organization. Staff were hired for each PTO area and Independent First Nations. Information sessions were held and all communities were advised about the new program.

Many challenges were experienced. It was important to allow time for First Nations or groups of First Nations to establish their process with respect to how they would proceed with this important program initiative. The process was to provide the information, allow time for discussion and to seek clarification and direction. First Nations with existing Long Term Care initiatives in place commenced program design for early program implementation.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- The communication plan identified in the initial work plan was not developed leading to some confusion during the information sharing process. All partners are endeavoring to develop an open and transparent process to improve communication;
- The development of terms of reference for working groups will assist in the communication process; and
- Ontario region is a diverse area and extensive travel requirements impedes the information being delivered in a timely manner. Information sharing activities needs to be clarified and both partners must have the same information prior to it being delivered to the communities. Partners are aware of this need and are endeavoring to clarify issues.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

- At the regional Working Group level, networking with DIAND and other agencies has been ongoing. Communities are undertaking the needs assessment process. Discussions are taking place at the community level regarding the linkages to the Adult Care program. Discussions need to be undertaken with the Ministry of health and

Long Term Care regarding the opportunities to link the Home and Community Care program with the Long Term Care program and how this might best be achieved.

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Home and Community Care coordinators participated in a training workshop in Toronto as well as an orientation/information session held in Ottawa;
- Each PTO and Independent First Nations held a formal orientation session with member First Nations with additional informal meetings held to answer questions and provide clarifications;
- Information sessions were held with senior managers in Thunder Bay and Sioux Lookout zones and with the Health and Social Advisory Board in Sault Ste. Marie; and
- Partners introduced the Home and Community Care program to the Chiefs of Ontario General Assembly held in Thunder Bay.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- A consultant was contracted to carry out an environmental scan on the current programs available to provide the anticipated training required. Environmental scan completed and being prepared for release to Ontario First Nations. Training plan is under development; and
- A training strategy to meet the training needs of the isolated and remote communities will be developed.

Quebec Region

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- Discussion held with DIAND, the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and Health Canada to establish a regional implementation process;
- Year One Regional Work plan completed and reported against; and
- Medical Services Branch, the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and the Nunavik Regional Board of Health and Social Services (NRBHSS) have employed program specific coordinators.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- Contribution agreements signed with Nunavik Regional Board of Health and Social Services; and the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) which established the working relationship for this new program with clearly defined roles and responsibilities;
- The First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) took the lead role in organizing the information sharing sessions held for communities in Quebec Region. Participants also included the Mayors of the Inuit communities of Nunavik; and
- A pre-screening and follow up process for all Needs Assessment Reports submitted has been established and involves all partners.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- Information Sharing and Feedback session held during the summer of 1999 with 51 participants in attendance;
- Region wide workshop held in February 2000, with 60 participants, to launch and distribute planning resource tool kit and provide information about program criteria and planning requirements;
- Distribution plan of all program specific information has been developed to facilitate timely distribution in an organized manner; and
- Ongoing community support provided through regular telecommunications.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

- Meetings have been held with DIAND, provincial representatives and discussions are underway to define the future participation of these significant stakeholders; and
- Both DIAND and provincial representatives have attended and participated in both information sharing meetings.

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Quebec region participated in both pilot training opportunities offered.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- 50 of 52 communities in Quebec Region received funding to initiate planning activities for the new program.

Atlantic Region

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- Two program coordinators have been employed to assist the communities with planning activities;
- Regional Steering committee has been established.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

Workplan developed wit targeted dates for completion of needs assessment, peer review training and the development of training and capital plans.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- Region wide workshop, multi community information sessions and community visits by program coordinators are some of the communication activities undertaken to inform communities about the program and planning expectations; and
- Two Information Sharing and Feedback sessions held in the Atlantic during the Summer 1999.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

Priority given to building linkages and a collaborative process between First Nations and Inuit and FNIHB.

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

Determining training requirements for frontline workers and regional team.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- 100% of the communities have received an allocation to initiate planning for new program.

Yukon Territory

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- Discussions initiated to develop a Regional Steering/Implementation Committee that would be tripartite in nature.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- Drafted philosophy, mission, objectives at territorial planning session February 1999; and
- Discussed Steering Committee membership at territorial planning session February 1999.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- Two regional Information Sharing and Planning sessions were organized by the Council of Yukon First Nations using co-facilitation process: January 2000, Haines Junction, Yukon, site of the pilot FNIHCC and Whitehorse February 2000.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

- Temporarily staffed FNIHCC manager position; created a new classification for the program manager position;
- Worked towards developing relationship and began formal partnership process between Yukon First Nations and Yukon Territorial Government Bureau of Statistics;
- Initiated program planning with Yukon First Nations, Yukon Territorial Government, Department of Indian and Northern Affairs, Human Resource Development Canada and other stakeholders;
- Coordinated agendas for meetings, work plan development, identified existing services and mandates for delivery, drafted guidelines, identified on-going needs; and
- Conducted presentations: steering committee updates (Yukon First Nations Health Commission, Yukon Territorial Regional Nursing).

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Training: assisted in development, coordination and facilitation of training with Yukon First Nations to build capacity in relation to FNIHCC;
- Community Development: assisted Yukon First Nations with proposal writing, networking, monitoring, consultation and collaboration; and
- Visited communities to provide assistance with identifying and articulating issues specific to FNIHCC.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- Four communities obtained funds to initiate creating awareness within their First Nations as part of the 'Getting Started' phase of the FNIHCC planning process.

Northwest Territories

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- There is an existing infrastructure for home care in NWT and the Home Care Coordinators report to the regional Health and Social Services Boards.
- Home Care Coordinators collaborate with their local and regional First Nations and Inuit organizations and Non-Government Organizations.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- Regional discussions have taken place to support the development of a territorial working group which includes First Nations and Inuit representation; and

- Working group will coordinate the planning for the enhanced Home Care program.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- Monthly conference calls with the regional Home Care Coordinators are conducted in addition to regular and ongoing e-mails, telephone calls, mail-outs, faxes.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

- GNWT funded to host three workshops to plan how home and community care services could be enhanced, integrated and coordinated with the existing NWT Home Care program. Approximately 120 people participated from First Nations and Inuit communities, Health and Social Services Boards, health professionals, Elders, seniors organizations and home care clients.

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Through conference calls and continued dialogue with the Home Care Coordinators the Department of Health and Social Services can determine what the program and developmental needs are in the regions.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- Regional community needs assessments were previously completed and Government of Northwest Territories are in the process of completing an environmental scan.

Nunavut Territory

Objective

To establish the infrastructure and collaborative processes required within regions and territories to facilitate program development and implementation.

Achievements

- Northern Secretariat is supporting Tripartite Steering Committee process and Terms of Reference have been developed; and
- Establishment of three Regional Working Groups, tripartite in nature, for the purpose of assisting community planning committees and reviewing Community Service Delivery plans.

Objective

To develop the planning process that would support the achievement of both the program vision and objectives.

Achievements

- Northern Secretariat is providing the support for Nunavut to assume the lead role for the planning of this program;
- Nunavut communities visits were planned by Inuit and the Government of Nunavut, in order to introduce the new FNIHCC program to each community; and
- Joint letter signed by the Government of Nunavut, NSDC and Health Canada was sent to each Nunavut community, announcing the purpose of the upcoming community visits.

Objective

To establish processes to facilitate timely communication and information sharing on program development and implementation.

Achievements

- Communication materials were developed which included further translation of the program flowchart, the FNIHCC Resource Kit in Inuktitut and in Innuinaqtun; a video was also produced in Inuktitut by the Inuit Broadcasting Corporation on one of the two existing Home Care programs in Nunavut;
- Program resource material was distributed to all 27 Nunavut communities; and
- 4 meetings took place with NSDC, Nunavut Technical Institute, the 3 Regional Inuit Organizations and with the Government of Nunavut officials.

Objective

To foster development of networking and linkages with programs and organizations to enable access to the "right care at the right time".

Achievements

- Linkages with other health care providers is being facilitated in the planning process.

Objective

To facilitate capacity building at all stages of program development and implementation.

Achievements

- Development of Training plan will be carried out with Government of Nunavut, Health and Social Services and Inuit partners.

Objective

To enable communities to commence needs assessment and planning/training activities for service delivery.

Achievements

- Information sessions are being planned for all 27 communities.

SUMMARY OF EXPENDITURES

(FOR FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE PROGRAM, BY PROGRAM ACTIVITY CODE)

1999-2000 Fiscal Year	
Management and Support	$3.9M
Needs Assessment and Delivery	$8.3M
Service Delivery	$.7M
Capital	$.3M
Training	$1M
TOTAL	**$14.2M**

OVERVIEW OF OBJECTIVES AND PRIORITIES 2000-2001

The National Steering Committee objectives for Year Two build on those described for Year One and include:

- To ensure that a collaborative process to all aspects of program development and implementation is carried out;
- To monitor regional and territorial planning activities and respond to developmental needs;
- To continue to facilitate communication and information sharing on all program developments with all stakeholders;
- To identify the barriers and opportunities to realize a continuing care continuum that supports the client receiving the "right care at the right time";
- To identify and strategically address ongoing capacity building issues;
- To enable the majority of communities to complete service delivery plans for the home and community care program;
- To build an information infrastructure and evaluation framework that will support community based planning and evaluation; and
- To support the development of resources that will enable quality care services.

Some of the activities that will be carried out to meet the above objectives will include:

- Development, distribution of generic program standards and policies;
- Development of description of required nursing competencies for the delivery home and community care services;
- Develop and implement a program development monitoring and tracking database to enable the National Steering Committee to oversee developments;

- Development of evaluation framework;
- Development of information module;
- Develop strategy to understand housing needs of clients receiving home care services;
- Develop framework to increase awareness and opportunities to incorporate technology and telehealth in health service delivery;
- Support ongoing monitoring and policy direction by the National Steering Committee;
- Support working group development activities including NIHB linkages strategies to access equipment of home care;
- Support collaborative developments and capacity building in all regions and territories;
- Completion, distribution and building an awareness with respect to issues related to liability; and
- Building linkages with other programs e.g., Diabetes.

CONCLUSION

The Annual Report is intended to provide an overview of developments both nationally and by regions. As evidenced in the report, each region is developing at its own pace and are in varying developmental phases. While each region/territory carries out its business in its own manner, there is knowledge to be gained from each region about how they are realizing program development. Program managers and individual communities are encouraged to connect with colleagues in other regions to gain access and understanding to resources they may have developed to help them implement this new program.